

THE MEDICAID PROGRAM AT A GLANCE

Medicaid is the nation's principal safety-net health insurance program, covering health and long-term care services for nearly 60 million low-income Americans, most of whom would otherwise be uninsured. Medicaid's enrollees include children and parents in working families, people with disabilities, and seniors; many of the nation's sickest and frailest people depend on Medicaid for their coverage and care. During the recession and as private insurance has eroded, Medicaid has provided a safety-net for millions of individuals and families who have lost their coverage. Under health reform, Medicaid's coverage role will increase significantly as it is expanded to reach millions more low-income people, mainly uninsured adults.

Since its inception in 1965, Medicaid has improved access to care for low-income people, paid a large share of the nation's bill for nursing home and other long-term care, and supported the safety-net hospitals and health centers that serve low-income and uninsured people. The Medicaid program funds 16% of all personal health spending in the U.S.

Medicaid is a federal-state partnership. The federal government and the states share the cost of Medicaid, and states design and administer their own Medicaid programs within broad federal rules.

Who does Medicaid cover?

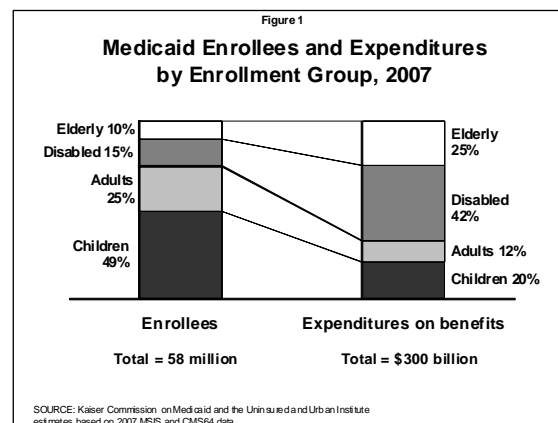
Under current law, to qualify for Medicaid, a person must meet financial criteria and belong to one of the "categorically eligible" groups: children; parents with dependent children; pregnant women; people with severe disabilities; and seniors. States must cover individuals in these groups up to specified income thresholds and cannot limit enrollment or establish a waiting list. Non-disabled adults without dependent children are categorically excluded from Medicaid by federal law unless the state has a waiver or uses state-only dollars to cover them. Finally, among Medicaid's elderly and disabled enrollees are more than 8 million individuals who have Medicare too. They are known as "dual eligibles."

Many states have expanded Medicaid beyond federal minimum standards, mostly for children. Many states also cover the "medically needy," categorically eligible individuals who exceed Medicaid's financial criteria but have high medical costs.

About half of Medicaid's beneficiaries are children. Non-elderly adults make up one-quarter. The elderly and individuals with disabilities account for another quarter (Fig. 1.) In 2007, Medicaid covered:

- 29 million children (1 in every 4)
- 15 million adults (primarily poor working parents)
- 6 million seniors
- 8.8 million persons with disabilities (including 4 million children)

Under health reform, beginning in 2014, nearly everyone under age 65 with income up to 133% of the federal poverty level (FPL) will be eligible for Medicaid. Categorical restrictions will be eliminated for this population. These changes establish Medicaid as the coverage pathway for low-income people in the national framework for near-universal coverage laid out in the health reform law. Medicaid eligibility rules for the elderly and disabled will not change under health reform.



What does Medicaid cover?

Medicaid covers a wide range of benefits to meet the diverse and often complex needs of the populations it serves. In addition to acute health services, Medicaid covers a broad array of long-term services that Medicare and most private insurance exclude or narrowly limit. Medicaid enrollees receive their care mostly from private providers, and over 70% receive at least some of their care in managed care arrangements. Medicaid programs are generally required to cover:

- inpatient and outpatient hospital services
- physician, midwife, and nurse practitioner services
- laboratory and x-ray services
- nursing facility and home health care for individuals age 21+
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- family planning services and supplies
- rural health clinic/federally qualified health center services

In addition, states can elect to offer many "optional" services, such as prescription drugs, dental care, durable medical equipment, and personal care services. All Medicaid services, including those considered optional for adults, must be covered for children. Medicaid assists dual eligibles with their Medicare premiums and cost-sharing and covers key benefits not covered by Medicare, especially long-term care.

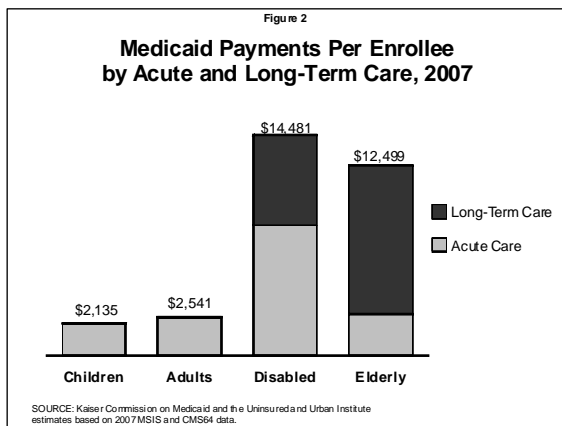
Generally, the same Medicaid benefits must be covered for all Medicaid enrollees statewide. However, states have some authority to provide some groups with more limited benefits modeled on specified "benchmark" plans, and to cover different benefits for different enrollees. Premiums are prohibited and cost-sharing tightly is limited for beneficiaries with income below 150% FPL. Less restrictive rules apply for others, but no beneficiaries can be required to pay more than 5% of their income for premiums and cost-sharing.

Under health reform, beginning in 2014, adults newly eligible for Medicaid due to health reform will receive a benchmark benefit

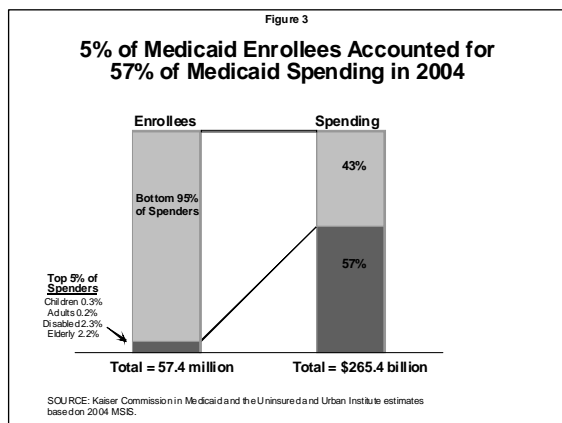
package, or a broader set of benefits if a state elects. The health reform law requires that benchmark benefit packages include at least the “essential health benefits” that health plans in the new insurance exchanges will be required to cover.

How much does Medicaid cost?

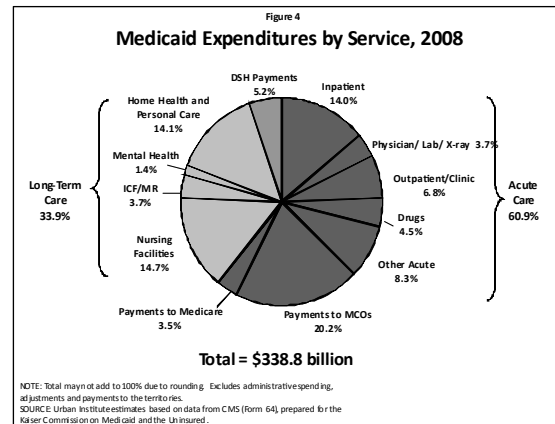
In 2008, Medicaid spending for services totaled about \$339 billion. Medicaid spending is not distributed uniformly across all enrollees. Although the elderly and people with disabilities comprise one-quarter of Medicaid enrollees, they account for roughly two-thirds of Medicaid spending. This pattern reflects the higher per capita costs associated with these individuals due to their more intensive use of both acute and long-term services. In 2007, Medicaid expenditures were about \$14,500 per disabled enrollee and \$12,500 per elderly enrollee, compared to \$2,100 per child and \$2,500 per non-elderly adult (Fig. 2).



Medicaid spending is also skewed due to the mix of relatively healthy people and very sick people the program covers. In 2004, the 5% of Medicaid enrollees with the highest health and long-term care costs accounted for over half of all program spending (Fig. 3). About 45% of total Medicaid spending is for dual eligibles.



Medicaid spending is distributed broadly across services (Fig. 4). In 2008, 61% of spending was for acute-care services and 34% was for long-term care. About 5% was attributable to supplemental payments to hospitals that serve a disproportionate share of indigent patients, known as “DSH.” Payments for Medicare premiums accounted for 3.5%.



How is Medicaid financed?

The federal government and the states share the cost of Medicaid through a matching system. The federal share is known as the Federal Medical Assistance Percentage, or FMAP. Normally, the FMAP is at least 50% in every state but higher in poorer states, reaching 76% in the poorest state, and the federal government funds about 57% of Medicaid costs overall. However, to provide fiscal relief to states during the recession, the American Recovery and Reinvestment Act (ARRA) included a temporary increase in the FMAP. As a condition of receiving the increase, states cannot reduce their Medicaid eligibility levels or use more restrictive methods in determining eligibility. These requirements help to preserve coverage. With the ARRA adjustment, the FMAP ranges from 56% to 85% for the 27-month period ending December 31, 2010. The enhanced FMAP increases the federal share of Medicaid spending overall to 66%.

Under health reform, the federal government will provide substantially increased Medicaid funding to the states. For the first three years (2014-2016), the cost of coverage for new Medicaid eligibles will be 100% federally financed. The federal share will phase down gradually, leveling out at 90% for 2020 and thereafter.

Looking ahead

As significant a source of coverage as Medicaid is today, under health reform the program will play a much larger and more national role, providing coverage to an estimated additional 16 million people. This expanded role presents unprecedented opportunities and challenges. Among the most important are achieving strong participation, ensuring that enrollees have adequate access to care, and developing seamless coordination between Medicaid and the new insurance exchanges.

Health reform will provide substantial additional federal funding for Medicaid beginning in 2014. But at present, states continue to face severe budget pressures. Resources to help states weather the recession and implement reform are critical. Enhanced FMAP has been an effective vehicle for federal assistance to states through the recovery. Stable, adequate federal help will be important to secure states’ capacity to preserve Medicaid coverage and smooth progress toward implementation of the Medicaid expansion and health reform overall in 2014.

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